The Effects of Family Conflict Resolution and Decision Making on the Provision of Help for an Elder With Alzheimer's Disease

Lawrence Fisher, Morton A. Lieberman
This study explored how characteristics of multigeneration families of patients with Alzheimer’s disease (AD) affected the family’s ability to provide help to their ill elder. An intensive patient and family assessment battery was employed with 211 families with an elder with AD, and measures of the amount and kind of help offered by the family group were recorded. Above and beyond control variables, families that used a focused decision-making style and positive conflict resolution methods provided more help than families that did not use these styles and methods. These data suggest the importance of the family system of care in disease management.

Key Words: Family, Alzheimer’s disease, Caregiving

The Effects of Family Conflict Resolution and Decision Making on the Provision of Help for an Elder With Alzheimer’s Disease

Morton A. Lieberman and Lawrence Fisher

The problems associated with the delivery of care by offspring to their aging parents increases as parents become ill and require more care. For example, families caring for a parent with Alzheimer’s disease often experience ongoing conflicts concerning such issues as what to do about a parent’s continued desire to drive a motor vehicle, how care tasks should be shared among family members, and when placement into a nursing home should be considered. A fuller understanding of the process of family decision making and care sharing for ill elders has been limited, by and large, by an often singular focus on the “primary” caregiver that excludes the contributions of other active family members. When other family members are studied, their caregiving is usually described through the use of “support” nomenclature, which, in our view, provides a restrictive framework for understanding the underlying processes through which family caregiving is organized and delivered.

This study adopted a broad view of the caregiving arena by exploring the role of the multigeneration family, not just the primary caregiver, on the amount and type of care that is provided to a dementing elder. Specifically, we tested the hypothesis that the ways in which families successfully address the disagreements and conflicts that inevitably arise over time affect the amount of help that second generation family members are willing to provide. Addressing the dynamics of caregiving within the family using this broader perspective is particularly important for programs of clinical evaluation and intervention.

A review of published studies suggests that many factors affect the amount of help provided by the second generation to ill family members of the first generation.Adult offspring are more likely to provide care when they are women (Dwyer & Coward, 1992), when they live near their parent (Finley, Roberts, & Banham, 1988), when they are an only child (Coward & Dwyer, 1990) or the oldest child (Hanson, Sauer, & Seelbach, 1983), and when they are divorced, widowed, or never married (Stoller, 1983). Competing work roles (Brody & Schoonover, 1986) and other family obligations (Stoller & Pugliesi, 1989) reduce the ability of adult offspring to provide care to their aging parents. Furthermore, changes in elders’ health status and function (Cicirelli, 1981; Stoller, 1983), marital and living arrangements (Horowitz, 1985), age (Soldo & Myllyluoma, 1983), and economic resources (Riley & Foner, 1968) also are important predictors of the participation of offspring in parental care. Cicirelli (1992) suggested that the care of aging parents is a developmental task of the entire sibling group over the life span.

Several studies support the contention that the organization and effectiveness of adult offspring involvement in caregiving influences the amount and type of care provided to an ill elder. For example, Dwyer, Henretta, Coward, and Barton (1992) explored changes in adult offspring caregiving over time. They found that 50.7% of those offspring who provided activities of daily living (ADLs) assistance and 29.9% of those who provided instrumental activities of daily living (IADLs) assistance initially stopped doing so during...
the subsequent years. This finding suggests that the participation of adult offspring in caregiving changes over time, often independently of the elder's continued, and often increased, needs for assistance. Caregiving behavior of adult offspring is also influenced, at least in part, by the caregiving behavior of other offspring. Dwyer and colleagues (1992) reported that the probability of one offspring providing care was directly related to the probability of their siblings providing care: if one helped, the others did as well.

Coupled with this apparent unanimity of caregiving among adult offspring from the same family is the finding that adult sons and daughters provide care in different ways, and that the roles they play and the impact caregiving has on their lives differ. Daughters are more likely than sons to provide high levels of personal and home-based care (Chang & White- Means, 1991; Dwyer & Coward, 1991; Horowitz, 1985), whereas sons are more likely than daughters to provide assistance in home repair, financial management, and maintenance (Stoller, 1990). Taken together, sons and daughters who manage their respective care providing roles well and who develop effective means for dealing with decision making and conflict resolution provide complementary caregiving behaviors to their aging and at times ill parents.

A Family Framework

Considerable data suggest that characteristics of the family unit are linked with its ability to manage a major health care crisis over time, e.g., diabetes (Hauser, Jacobson, Wertzlieb, Brink & Wentworth, 1985), cancer (Soccorsi, Lombardi, & Paglia, 1987), and cardiovascular disease (Medalie & Goldbourt, 1976). For example, family beliefs, structures, and styles have been associated with compliance with medical regimens (Rolland, 1994), frequency of hospitalizations (Doane, Falloon, Goldstein, & Mintz, 1985), use of health care facilities (Schor, Starfield, Stidley, & Hanks, 1987), reported family member health and well-being (Fisher, Ransom, & Terry, 1993), display of health risk behavior (Fisher & Feldman, 1998), and post-illness recovery (Medalie & Goldbourt, 1976). In general, the following family variables have received the most attention and have demonstrated the most consistent links with poor response to chronic disease: low family cohesion, high family conflict, too rigid or too permeable family boundaries, low levels of family organization, distant or hostile family affiliative tone, criticalness, lack of clear communication, and poor spousal support (Fisher, Ransom, Terry, Lipkin, & Weiss, 1992).

Despite the rapid proliferation of empirical studies examining the relationships among family members caring for an elder with Alzheimer’s disease, the vast majority of research has not addressed the family as an integrated system responding to and being affected by the presence of disease. There has been an increased interest, however, in the importance of the family in understanding variations in disease management behavior. Some studies report that emotional support from siblings (Horowitz, 1985) and other relatives (Zarit, Reever, & Bach-Peterson, 1980) mediates caregiver strain. Other studies document the problems of conflict and disturbed relationships among family caregivers. For example, Brody (1989) reported that between 45% and 60% of primary caregivers complained that their siblings failed to help as much as they should. Matthews and Rosner (1988) found that sibling conflict is sometimes exacerbated to the point that responsibilities can no longer be shared.

Overall, the central focus of family research in caregiving for frail elders has centered on family conflict (Abel, 1987; Archbald, 1983; Frankfather, Smith, & Caro, 1981; Haussman, 1979; Smith, Smith, & Toseland, 1991). Sturibergen (1990) reported that those families she characterized as involving “structured conflict” perceived a greater impact of illness than those families she characterized as “cohesive.” Furthermore, Strawbridge and Wallhagen (1991) reported that 40 of 100 adult offspring caregivers experienced serious conflict with other family members and that family conflict correlated significantly and positively with caregiver burden and poor reported health.

Studies also suggest that how families care for an elder with Alzheimer’s disease is associated with the self-reported health and well-being of the patient’s spouse, offspring, and offspring spouses, or in-laws. Fisher and Lieberman (1994) used 12 indicators of family functioning grouped into three behavioral domains of family life, world view, structure/organization, and emotion management, and found that adult offspring and in-laws displayed variations in anxiety/depression, somatic symptoms, and well-being as a function of these qualities of the family system. Fisher and Lieberman (1996) examined the consistency and change in family and health relationships over time. They found that the use of mechanisms to avoid family conflict and the use of guilt by family members as a means of control assessed at baseline led to a significant reduction in offspring health and well-being over a two-year period. Furthermore, family avoidance of conflict was associated with increased adult offspring vulnerability to the effects of increasing patient-care distress over time. Lieberman and Fisher (in press) found that characteristics of the family system either contained or exacerbated the stresses of caregiving from affecting other, non-disease-related family role behaviors, in this case marital role functioning. Last, Lieberman and Fisher (in press) showed that characteristics of the family were linked to the family’s use of professional services for patient care, as recommended by clinic evaluation. Families that did not follow through had fewer disagreements and reported closer family relationships over time than families that did follow through on clinic recommendations. These “closer” families preferred to undertake caregiving themselves, without the assistance of professional or community services.

These studies suggest that how family members structure themselves to address the complexities of caring for an elder with dementia has an impact on the conditions of care, the follow-through on clinic recommendations and the subsequent health and well-being of all family members. The present study addresses these issues further by examining another critical behavioral issue in caregiving: the amount and
kind of help offered by family members to the ill elder with dementia. Our primary research question concerned how the help offered by family members in the care of an elder with dementia was influenced by their style of decision management and conflict resolution regarding caregiving issues. We hypothesized that families that handled decision making well and that used effective methods of conflict resolution would work together better and, therefore, would provide more help to their ill elder than families that did not.

Methods

Sample

Patients and their families were recruited from the California Alzheimer’s and Memory Disorders Clinics located in San Francisco, Davis, Fresno, Palo Alto, Los Angeles, San Diego, and Irvine. Each clinic sees an average of 130 new patients and their families per year for comprehensive diagnostic and management/care planning, and most families are followed for re-evaluation yearly. The clinics are multidisciplinary; their diagnostic procedures include neurological, family, medical, psychiatric, and social evaluation, as well as advanced diagnostic imaging procedures. The patient’s behavior and environment are evaluated during a home visit by a clinic staff member. Each patient’s medical, behavioral, and environmental findings are reviewed in a clinical case conference to arrive at a consensus diagnosis and care plan. Three to four weeks after the staff conference, family members attend a feedback meeting in which the diagnostic recommendations and care plan are discussed.

Inclusion criteria for the study were: the patient met National Institute of Neurological and Communicative Disorders and Stroke (NCCCD) diagnostic criteria for probable or possible Alzheimer’s dementia; at least one adult offspring resided in California; and the patient lived in the community, either with a spouse, relative, or alone. All patients and families meeting these criteria were referred by the respective clinics to the research team following completion of the family feedback conference.

Of the 533 families referred by the clinics, 198 did not fully meet inclusion criteria. Of the remaining 335 families, 100 refused to participate, yielding a 70% acceptance rate. Twenty families provided partial data and were dropped from analysis. The total sample included 211 families.

The study included only adult offspring because previous studies indicated that spouses tended to present their families in a highly favorable light. This positive bias limited variations among families (Fisher & Lieberman, 1994). The data from only one offspring per family was included in analyses to assure independence among respondents (in 13 families the offspring was not available and the clinics designated an in-law who was most involved in ADLs/IADLs care). Preliminary analysis indicated no differences between offspring and in-law responses on any of the measures included in this article. Characteristics of the patient and respondent sample are presented in Tables 1 and 2, respectively.

Using the clinics’ shared, computerized database, analysis of data between the 120 families that refused or were dropped and the 211 that participated yielded no significant differences in clinic location, reasons for seeking evaluation, patient gender, ethnicity, marital status, living arrangements, income, patient education,

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>133</td>
<td>63</td>
</tr>
<tr>
<td>Female</td>
<td>78</td>
<td>37</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>African American</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>169</td>
<td>81</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living arrangements</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone</td>
<td>38</td>
<td>18</td>
</tr>
<tr>
<td>With spouse only</td>
<td>99</td>
<td>47</td>
</tr>
<tr>
<td>With spouse &amp; offspring</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>With offspring</td>
<td>49</td>
<td>23</td>
</tr>
<tr>
<td>With non-relatives</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of education</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.98</td>
<td>4.1</td>
</tr>
<tr>
<td>Mini-Mental Status Exam</td>
<td>15.80</td>
<td>7.0</td>
</tr>
<tr>
<td>Blessed Roth Dementia Rating Scale</td>
<td>4.87</td>
<td>5.6</td>
</tr>
<tr>
<td>Number of neurological signs</td>
<td>1.50</td>
<td>1.9</td>
</tr>
<tr>
<td>Number of other illnesses</td>
<td>2.43</td>
<td>2.1</td>
</tr>
<tr>
<td>Number of dementia-related problems</td>
<td>4.68</td>
<td>1.9</td>
</tr>
<tr>
<td>Number of psychiatric symptoms</td>
<td>6.47</td>
<td>4.8</td>
</tr>
<tr>
<td>Number of services used</td>
<td>2.78</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Table 2. Characteristics of Offspring/In-laws (N = 211)

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>80</td>
<td>38</td>
</tr>
<tr>
<td>Female</td>
<td>131</td>
<td>62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>Married</td>
<td>153</td>
<td>73</td>
</tr>
<tr>
<td>Divorced or separated</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;11 years</td>
<td>44</td>
<td>21</td>
</tr>
<tr>
<td>High school</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>Some college</td>
<td>41</td>
<td>19</td>
</tr>
<tr>
<td>College graduate</td>
<td>73</td>
<td>35</td>
</tr>
<tr>
<td>Post-college</td>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>Work status</td>
<td>N</td>
<td>Percent</td>
</tr>
<tr>
<td>&gt;50% Time</td>
<td>173</td>
<td>82</td>
</tr>
<tr>
<td>&lt;50% Time</td>
<td>38</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children</td>
<td>2.2</td>
</tr>
<tr>
<td>Care hours per week</td>
<td>2.7</td>
</tr>
<tr>
<td>Nuclear family size</td>
<td>2.5</td>
</tr>
</tbody>
</table>
number of primary and secondary caregivers, or scores from the Mini-Mental State Exam, Blessed Roth Dementia Rating Scale, Blessed Orientation Cognitive Test, diagnosis, or number of patient problems. Hence, the sample appears representative of the population served by the California clinics.

**Procedure**

Family members were contacted by the research team after the clinic feedback conference. The patient’s spouse was called first to determine if the family met the inclusion criteria. If so, the offspring (or in-law) was contacted, and she or he became the primary family respondent. Agreement to participate involved the offspring completing a 197-item questionnaire and a 45-minute tape-recorded telephone interview (we were unable to complete the interview for nine subjects, and these were included among the 20 families dropped from analysis because of incomplete data).

**Measures**

**Patient Characteristics.**—Six patient measures, assessed by the clinics using uniform criteria, were used to measure severity of patient problems: level of cognitive disturbance (Mini-Mental State Exam; Folstein, Folstein, & McHugh, 1975), level of functioning (Blessed Roth Dementia Rating Scale; Blessed, Tomlinson, & Roth, 1968), number of psychiatric symptoms (psychiatrist’s rating of nine symptoms using DSM—III criteria), number of neurological signs and symptoms (neurologist’s rating), number of other health problems (physician’s rating based on a history and physical exam), and number of patient problem behaviors (clinical nurse’s rating of nine areas assessed at a home visit). A principal components analysis of the six patient characteristics yielded one factor, accounting for 67% of score variance. A factor score from this single component was used as an index of patient severity.

Each patient’s living arrangements was classified into a three-way categorical variable: living with spouse, living with an offspring (with or without a spouse), or living alone. Last, we asked each family member to rate the patient on a scale of “troublesomeness” based on a list of 17 patient problem behaviors (alpha = .83). Examples included: wandering or getting lost, asking the same question over and over, hiding things (money, jewelry), or being suspicious or accusative.

**Offspring/In-law Characteristics.**—Data were collected on offspring (or in-law) gender, distance in miles between the residence and the ill parent, offspring work status (50% or more time vs less than 50% time), age of youngest child, and minority ethnic group status. In addition, two measures of the respondent’s health and well-being were included: number of 13 somatic symptoms occurring regularly over the last three months (Ware et al., 1984), alpha = .93, and anxiety/depression (combined anxiety and depression scales from the Hopkins Symptoms Checklist; Derogatis, 1974; modified by Pearlin, Lieberman, Menaghan, & Mullan, 1981, alpha = .92).

**Family Characteristics.**—Family decision making and conflict resolution were assessed by four sets of interviewer ratings based on a tape-recorded, semistructured telephone interview. These scales assessed how offspring and in-laws made decisions and how they addressed the disagreements they experienced regarding the ill family member’s care. Interrater reliability (kappa) was established using a separate set of 20 pilot interviews and internal consistency (alpha) was based on scores from the entire sample.

The telephone interview began with the following question: “I would like you to tell me about a situation in which your family has had to make a decision regarding Mr./Mrs. X’s care or about arrangements that had to be made for him/her. Please tell me about a situation like this and how you went about making a decision.” The respondent defined for her/himself the problem area. Two sets of interviewer questions followed the respondent’s presentation of the decision-making situation. Positive decision making techniques was based on a 9-item, yes/no scale that asked the respondent to state how the family came to their decision. Items included: did your family consult an expert in the field, ask an advisor (clergy, friend), list alternatives, go around and around, not deal with it, divide up the tasks, reach a stalemate (dead end), feel you worked too hard for too little results, and read books or literature. The number of positive methods was used as the indicator score (alpha = .72). Focused decision making was based on a summed composite of two interviewer ratings. The first was a rating of who made the final decision. Options included: one person with little or no input from others, one person with some discussion with others, active discussion by all family members with one person deciding, and shared or democratic decision making (reverse coded, kappa = .78). The second was a rating of how much verbal discussion occurred among family members, using a 5-point scale from “minimal or not at all” to “a great deal” (kappa = .73).

The conflict resolution scales were based on the respondent’s answer to the following telephone interview question: “I’d like you to tell me about a disagreement or difference of opinion that is occurring in your family now about caring for Mr./Mrs. X. Something that is important to the family and about which you do not agree.” Positive conflict resolution was based on a 6-item scale that asked the respondent how often the following occurred regarding the disagreement: a person or group of family members gave in; a compromise occurred; the conflict was avoided; the family worked hard to resolve it; we handled it positively; members felt pressured or coerced. A 5-point scale from “always” to “rarely or never” was used for each item (reverse coded, alpha = .61). Task focus was based on a 5-point rating from “always task focused” to “very often of task” in response to: “When you have a disagreement in your family, how hard is it for the family to stay on the topic? Do you tend to
get diverted or lose track easily, or can you generally stay on the topic” (kappa = .90).

**Dependent Variable.**—The respondent was then asked about the “things you did to help care for Mr./Mrs. X” during the last six months. Responses were coded into eight content areas: shopping, finances, errands, transportation, personal care, food preparation, laundry, and home maintenance. If help was provided in a particular content area, frequency of help was also recorded (daily, 2–6 times per week, once per week, 1–3 times a month, occasionally). Similarly, each respondent was asked if care was provided by other family members in each content area, and if so, frequency of help was recorded. Adding the respondent’s help score to the “other family member” help score created the total family help score used in the analyses reported below. The total family help score was used in all analyses because we were interested in how much help the family as a group provided to the patient. This score was unrelated to family size (r = .09) and was significantly related to estimates of total family help provided by other family members (r = .54).

**Data Analysis**

Our primary question was whether the four family decision-making and conflict resolution variables predicted the quantity of help provided by the family to the ill elder, after controlling for the effects of the other variables most often studied (for purposes of this article we label these “control variables”). Because of the number of control variables assessed, relative to the size of the sample, two sets of multiple regression equations were constructed.

In the first equation, 13 control variables were entered into a simultaneous regression equation, with total family help as the dependent variable, to explore the quantity of help provided. Significant, independent predictors from this equation were then identified.

Next, three equations were created to assess the role of the family variables in predicting help provided. Three equations were required because the number of potential interaction terms between the family variables and the control variables was too large, relative to sample size, to be included in a single equation. The three significant predictors identified in the first regression equation were entered into Step 1 and the four family variables were entered into Step 2 of all three equations. Step 3 included interaction terms between all four family variables and one of the three traditional variables entered into Step 1, thus yielding three separate equations.

**Results**

**Analysis of Traditional Factors**

The results of the simultaneous regression equation are presented in Table 3. The equation approached significance (R = .30, df = 12/198, F = 3.50, p = .08). Of the 13 traditional variables, two reached statistical significance: patient living with a spouse was negatively correlated with total family help (β = −.17, t = −2.14, p = .03); and respondent education was positively correlated with total family help (β = .16, t = 2.27, p = .02). Troubling behaviors approached statistical significance (β = .13, t = 1.74, p = .08), suggesting a positive relationship with the provision of family help.

**Analysis of Family Factors**

The three step-wise multiple regression equations indicated that none of the family by control variable interaction terms in Step 3 or the R² change for Step 3 approached or reached statistical significance (R² change for Step 3 = .005, .021, and .008). For ease of presentation, the results of only the first two steps are presented in Table 4. The two-step equation with
all variables entered reached statistical significance ($R = .37, df = 8/202, F = 3.70, p = .0001$). After controlling for the effects of living arrangements, education, and patient troubling behavior, a significant main effect occurred for positive conflict resolution ($\beta = .18, t = 2.6, p = .01$) and focused decision making ($\beta = .14, t = 2.00, p = .04$). The greater the family’s positive conflict resolution skills and the more focused their decision-making style, the more help the family provided.

Supplementary Analyses

Given the significant findings, we asked whether the provision of family help, and by implication the way the family structured itself for decision making and conflict resolution, affected a family’s decision to place their ill elder in a care facility during the two years subsequent to clinic evaluation. Our rationale was that the provision of family help, and the family-related factors that influence it, have important implications for family decisions to institutionalize: the less able the family was to provide help to their ill elder in the community, the greater the probability that the family might choose to institutionalize over time.

We had available follow-up data on this sample as part of a larger study. Data on placement were gathered from a brief, telephone interview administered every six months for two years following clinic evaluation. The sample of 211 families was reduced for this analysis by ten deaths and 25 drop-outs during the ensuing two-year period, leaving 176 families. Of these, 87 (49.4%) had been institutionalized during the two years following clinic evaluation.

A simultaneous logistic regression equation was constructed with institutionalization as the dependent variable. Three predictors were included: total family help, troubling patient behaviors, and patient severity (the correlation between patient severity, based on clinic evaluation, and troubled behavior, based on respondent perceptions is .27). The latter two variables were included to control for other indicators that might directly contribute to institutionalization, thus allowing the role of family help to be assessed more independently. The logistic regression equation reached statistical significance ($\chi^2 = 13.70, df = 3/172, p = .003$), with two of the three odds ratios reaching statistical significance: troubling behavior (OR = 1.39, $p = .01$); patient severity (OR = 1.09, $p = .52$); and family help (OR = 0.69, $p = .01$). As expected, family members who reported high levels of patient troubling behaviors more frequently institutionalized their ill elders than family members who reported low levels of patient troubling behaviors. After controlling for troubling behavior, families that provided high levels of help were less likely to institutionalize their ill elders than family members who reported providing low levels of family help.

Discussion

The increased national awareness of the need for family elder care is reflected by a large but somewhat narrow body of research, in our view. By and large, research has focused on the care provided by the “primary” caregiver, examining the motives and costs of caregiving. Caregiving within the context of the larger family system has been relatively less well studied (Dwyer & Coward, 1992).

The present study took as its central theme the view that every family has certain caregiving values, traditions and practices that account, in part, for the variations that families display when caring for ill elders (Brubaker & Brubaker, 1989; Gubrium, 1991). We addressed one aspect of the family’s style of management that shapes its response to elder care needs.

We found that three control variables are linked to the provision of family help: less family help is provided when the ill family member lives with his or her spouse than when they live alone or with offspring; more family help is provided when elders display troublesome behavior than when they do not; and more family help is provided when the adult offspring are educated than when they are not. All three findings were expected, given previous research.

Noteworthy are our findings concerning the linkages between characteristics of caregiving families and the provision of help. Families that use positive conflict resolution methods provide significantly more help than families that do not. Families that assign decision-making responsibilities to a single family member with at least some input from others provide more help than families that use more democratic but potentially more disorganized methods. Taken together, these findings suggest that the provision of family help is greatest when there is a family ethos of using effective methods for resolving conflicts among family members regarding caregiving and decisions about caregiving, and when the responsibilities for decision making are focused and concentrated on a single family member.

The absence of a significant interaction term in all three multiple regression equations and the very low $R^2$ change between Steps 2 and 3 suggests that the family effects on the provision of family help are not qualified by patient living arrangements, troubling behaviors, or offspring education, a surrogate for social class. This finding enhances the generalizability of the family effects to a broad range of multigeneration families.

These findings echo a recent study by Pyke and Bengston (1996) on variations in family caregiving among multigeneration families. They found that families organize their response to the caregiving needs of elders in one of two ways: one corresponds with the idea of individualism and the other with collectivism or familism. Collectivist families are more likely than individualist families to emphasize the emotional needs of the family, which provides a sense of continuity, belongingness, and family identity. In these families, emphasis is placed on kinship ties and familial responsibilities, which take precedence over other personal roles and obligations. Individualistic families, on the other hand, emphasize personal independence, self-reliance, autonomy, and loose kinship ties. Individualistic families minimize hands-on caregiving and rely...
instead on formal supports. They do not abandon their elderly parents, however, but instead serve as managers of the parents’ needs and maintain regular social contact. Collectivistic families personally assume care of frail elders, even when the demands for care are high.

The results of the supplementary analyses expand the primary findings concerning the provision of family help. Controlling for patient troublesomeness and severity, the more help provided by the family, the lower the probability that the family will institutionalize the ill parent during the ensuing two years. Characteristics of the caregiving family, therefore, may be indirectly linked with the timing of institutionalization. This finding suggests an important hypothesis for future research, namely that specific characteristics of the social context of care may significantly increase our ability to predict which families may institutionalize early in the disease process and which families may be unable to institutionalize even when the emotional and instrumental costs become high. Such data would have substantive implications for programs of intervention.

Several limitations of these findings need to be considered. First, the analyses of the primary research questions were based on cross-sectional, retrospective data supplied by family members. The predictive linkages among these variables were not assessed.

Second, we did not include variations in family appraisals by members of the same family in these analyses. This might have influenced the findings insofar as we selected the offspring most involved in care as the family respondent. However, other research suggests that correlations on family appraisals between offspring and in-laws are generally moderate (Fisher & Lieberman, 1996) suggesting that the linkages between family conflict resolution and decision making, and the provision of family help are relatively stable.

Third, our sample was predominately non-Hispanic White. Because family structures, beliefs, and styles of management vary by culture and ethnicity, these data cannot be directly generalized to ethnic minority families. Although we hypothesize that characteristics of the family context of care are linked to the provision of help and other management issues among ethnic minority families, we suspect that qualitative aspects of these patterns may vary from culture to culture.

The present study suggests the importance of addressing characteristics of the multigeneration family caregiving system in studies of clinical care for patients with dementia. Addressing family organizational patterns, world views, problem-solving skills, and emotion management styles may provide important new vehicles for intervention. This approach suggests an expansion of the perspective often used to observe caregiving, from the so-called primary caregiver to the broader social context in which decisions are made and care is delivered.

References


Received May 18, 1998
Accepted December 10, 1998

Serono Symposia USA, Inc.
Endocrinology of Aging
October 27-30, 1999, Tempe, Arizona

Scientific Committee
Barry B. Bercu, M.D., Richard F. Walker, Ph.D., Chairs
Marc R. Blackman, M.D., Michael Fossel, M.D., Ph.D.
Steven W.J. Lamberts, M.D.

The objective of this meeting is to review contemporary knowledge of basic and clinical aspects of aging as it impacts upon the endocrine system. Accordingly, part of the meeting will be devoted to understanding the pathophysiological causes of decay and dysfunction of endocrine tissues, of integration among the different neuroendocrine axes and of the cellular and molecular processes underlying endocrine senescence. This information is derived primarily from research in animals and will represent much of the preclinical logic for clinical interventions into the aging process. Current clinical interventions such as those involving hormone replacement therapy will be described, and more hypothetical approaches involving gene therapy will be discussed. The symposium will present "state of the art" applications of basic research to the human condition, as well as insight into future trends of endocrine aging research.

This symposium is designed for physicians, scientists, and other health professionals interested or trained in endocrinology, gerontology and geriatric, internal and family medicine.

AMA Category I credit hours will be awarded.

For further information, please contact:
Leslie Nies, President, Serono Symposia USA, Inc.
100 Longwater Circle, Norwell, MA 02061 USA
Telephone 800-283-8088 or 781-982-9000
Fax 781-982-9481

The Sociology Program at Coastal Carolina University invites applications for an Assistant Professor, tenure track position beginning August 1999. The successful candidate will have a Ph.D. in Sociology, research expertise in Social Gerontology, a demonstrated interest in undergraduate teaching and research, and will assist in helping to promote the Department's Gerontology Certificate Program.

Applicants should send vitae, statements of teaching and research interests, copies of transcripts, and three (3) letters of reference. Coastal Carolina University is a growing, state-assisted institution located 10 miles from Myrtle Beach. Consult our web page at http://www.coastal.edu. Send application to Chair, Sociology Search Committee, Coastal Carolina University, P.O. Box 261954, Conway, SC 29528.

Review of candidates will begin immediately and continue until the position is filled. Coastal Carolina University is committed to Equal Employment Opportunity and is eager to identify minority persons and/or women with appropriate qualifications.